Change Table for *MDS-ALS and RCA Manual*, Effective 6/2/22
Residential Care Facilities and Adult Family Care Homes

Section	Page	MDS-RCA Section	Item	Change	Date of change
	Title page		Document Title	Date change to June 2022	6/2/22
			Headers updated on all pages	Header updated to "*MDS Training Manual for Residential Care Facilities and Adult Family Care Homes, June 2022*"	6/2/22
			All references to "MDS-RCA"	All references to MDS-RCA have been changed to MDS as the information applies to the MDS for both residential care facilities and adult family care homes	9/1/20
	TOC1-TOC6		Table of Contents - attached	Section renumbered by Section of the Manual and Section of the MDS; Sections numbers 1 through 6	6/2/22
1.	1-2	1.2	Assessor Responsibilities: submissions	PNMI are required by policy to submit all assessments electronically and AFCH may submit assessments electronically if software is available. If software is not available, AFCH will submit completed assessments by mail or fax. All documents mailed or faxed must clearly identify the intended recipient and must be marked confidential.	6/2/22
	1-2	1.3	Facility Responsibilities	Section 1.25 changed to 1.3	6/2/22

	1-2		Transfer of Residents	Information added for clarification: Any time a resident is transferred to a new facility (regardless of whether it is a transfer within the same chain), a new assessment must be done within 30 days. When transferring a resident, the transferring facility must provide the new facility with necessary medical records, including appropriate MDS assessments, to support the continuity of resident care. However, when the admitting facility admits the resident, the MDS schedule starts from the date of admission with an Admission assessment. The admitting facility should review the previous facility's assessment, in the same way they would review other incoming documentation about the resident, for the purpose of understanding the resident's history and promoting continuity of care. The admitting facility must perform a new admission assessment for the purpose of planning care. When there has been a transfer of residents' secondary to disasters (flood, earthquake, fire) with an anticipated return to the facility, the evacuating facility should contact Division of Licensing (DLC) and the Office of MaineCare Services (OMS) for guidance. When the originating facility determines that the resident will not return to the evacuating facility, the provider will discharge the resident. The receiving facility will then admit the resident and the MDS cycle will begin as of the admission	6/2/22

				date. For questions related to this type of situation, providers should contact OMS.	
	1-4	1.4	Contacts with Caregiver Staff	Section 1.3 changed to Section 1.4	6/2/22
	1-5	1.5	Contacts with Residents	Section 1.4 changed to Section 1.5	6/2/22
	1-5	1.6	Confidentiality Requirements and Resident Rights	Section 2 changed to Section 1.6	6/2/22
2	2.1	2-1 through 2-5	General Procedures for Completing the Instruments	Section 3 changed to Section 2, information related to the completing assessments, interviews, recording responses, coding conventions, and sources of information	6/2/22
3	3	3-1	Overview to the Item-by-Item Guide to the MDS: Coding	Section 3.8 changed to Section 3 and new information added to Coding: The facility is responsible to ensure that all documentation to support the MDS coding is present and accessible in the clinical record, accurate and available for review.	6/2/22
	3.1	AA-1	Basic Assessment Tracking Form, Section AA	Section 4 changed to 3.1	6/2/22
	3.2	AB-1	Background Information		6/2/22
	3.3	A-1	Functional Assessment	First section of MDS proper. Numbering for each section matches the letter of that section.	6/2/22

		A-3	A6. Reason for Assessment 4. Semi-annual assessment	Clarifying information added: A new assessment is required within 180 days of the S2b date of the previous assessment, on an ongoing basis for as long as the resident resides in the facility, according to guidelines and time frames provided by the Department of Health and Human Services. If, at any time, a Significant Change in status assessment is submitted the "clock" will be reset for all subsequent assessments. If you are requested to perform another assessment by a nurse reviewer, the "time clock" will also be reset for all subsequent assessments	6/2/22
		B	No changes		6/2/22
		C	No changes		6/2/22
		D	No changes		6/2/22
		E	No changes		6/2/22
		F	No changes		6/2/22
	G-1	G	G1A.d dressing: references to "street clothing" were removed	Clarification for purposes of distinguishing resident's clothing and pajamas from typical hospital attire.	6/2/22
	G-4	G	Definition of Limited Assistance	Clarifying information added: **Limited Assistance** – Resident highly involved in activity, received physical help in guided maneuvering of limbs or other non-weight-bearing assistance on three or more occasions –OR- limited assistance one or two times and/or weight-bearing that equals a total of three occurrences during last seven days. (6/2/22)	6/2/22
		H	No changes		6/2/22

	I-1	I	I1. Intent:	Clarifying information added: To document diagnoses that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, monitoring, or risk of death. In general, these are conditions that drive the current service plan. Do not include conditions that have been resolved or no longer affect the resident's functioning or service plan. One of the important functions of the MDS assessment is to generate an updated, accurate picture of the resident's health status. All diseases and conditions must have physician-documented diagnosis in the clinical record. Functional limitations include loss of range of motion, contractures, muscle weakness, fatigue, decreased ability to perform ADLs, paresis, or paralysis.	6/2/22
	I-2	I1.v	Hemiplegia/ Hemiparesis	Clarifying information added: **v. Hemiplegia/Hemiparesis** – Paralysis/partial paralysis (temporary or permanent impairment of function and/or movement) of one side of the body. Usually caused by cerebral hemorrhage, thrombosis, embolism, or tumor. This is not simply weakness. There must be a relationship to a diagnosis or condition. The service or care plan needs to include the reason for the weakness.	6/2/22
	I-5	I1.	Coding:	Clarifying information added: Code only active diagnoses that drive the current service plan**.**	6/2/22
		J.	No changes		6/2/22
		K.	No changes		6/2/22
		L.	No changes		6/2/22
		M.	No changes		6/2/22

		N.	No changes		
		O.	No changes		
	P-4	P2.	Intervention Program for Mood, Behavior and Cognitive Loss	Clarifying information added: Intent: To record all interventions and strategies used in the last 7 days (unless a different time frame is specified). The clinical record must contain the following: 1. Documentation on the service plan that includes: A. the problem, situation, or challenge being addressed, B. the goal of the program, and C. Approaches to be used. 2. Documentation that the strategy was used within the 7-day look back period. 3. Evaluation of the P2 programming at the time of the MDS completion. How is the program working and should it be continued or revised? This must be documented before the assessment completion date (S2b). (6/2/22) There must be documented evidence of review and update with every assessment and as needed. The service plan should be treated as a living documented that is changed as the resident's care needs change. (6/2/22)	

	P-5	P2.e	Resident-specific deliberate changes in environment	Clarifying information added: Adaptation of the environment to address a resident's individual mood/behavior/cognitive patterns. Examples include placing a banner labeled “wet paint” across a closet door to keep the resident from repetitively emptying all the clothes out of the closet or placing a bureau of old clothes in an alcove along a corridor to provide diversionary “props” for a resident who frequently stops wandering to rummage. The latter diverts the resident from rummaging through belongings of other residents’ rooms along the way. Another example would be use of a “wander guard” or device that creates environmental changes, such as causing a door to lock, for the resident, but not the general population. (6/2/22)	6/2/22
	P-7	P3a/b	Need for ongoing monitoring	Clarifying information added: Process: The need for on-going monitoring of an acute condition (unstable, fluctuating, medically complex) or new treatment/medication must be documented by the physician or a Registered Nurse, including a description of what monitoring is required and what needs to be reported. ***Review the resident’s clinical record. Clinical records must contain documentation by the person coded as being responsible for the monitoring to show that monitoring has occurred during the look back period.***	6/2/22
		Q	No changes		
		R	No changes		
		S	No changes		
		T	No changes		

		U	No changes		
4.	4-1		Discharge Tracking Form	Section number changed from 7 to 4. No change in information.	
5.	5-1		Editing Completed Instruments	Section number changed from 8 to 5. No change in information.	
6.	6-1		Correction of the MDS	Note: This section applies to Residential Care Facilities only. Adult Family Care Homes do not have a policy regarding corrections. If an error is noted on an AFCH assessment, a new assessment will need to be completed.	
			Section formerly called 9. Semi Annual Assessment has been moved to A6. Reason for Assessment.	FYI	